

# Getting Started

**You can fill out the Medical Benefit Request (MBR) on your computer, then print it. Or, you can print a blank copy and fill it out by hand. Make sure you sign and date the MBR on page 4. Then send it with proof of your income to the address listed on the MBR instruction page.**

**To fill out the MBR on-line**, use the mouse to **click** on the first field you want to fill out **on each page**. Type the necessary information, then press the Tab key to move to the next field, or use the mouse to click on the next field. To fill a check box, click on the box using the mouse, or tab to the field, and when the box has a dotted line around it, press the Enter key. If you need to go back to another field, click on that field with your mouse. To go from one page to the next, tab to "Please go to the next page.", and when highlighted, press tab, or use the mouse to click on the first field on each page.

**After you print the filled-out MBR**, YOU MUST click on the "Clear entire form" button at the bottom of page 4. This will remove all the information you entered on the MBR so no one can see your personal information.

# Medical Benefit Request Instruction Page

## Please read these instructions before you fill out the application.

Dear Applicant:

This is your application for **MassHealth**, the **Children's Medical Security Plan (CMSP)**, **Healthy Start**, and the **Uncompensated Care Pool\***. MassHealth gives health-care coverage and helps pay for health-insurance premiums for families, children, and individuals. The kind of coverage you get depends on your family size, income, and other circumstances. After your application is filled out and reviewed, **you will be given the most complete coverage that you qualify for.**

Generally, this application is for people who live in Massachusetts, are not living in or about to go into a nursing home, and are under age 65. This application may also be used by people of any age who are parents of children under age 19, or who are adult relatives living with and taking care of children under age 19 when neither parent is living in the home, or who are disabled and work 40 or more hours a month. If this application is not for you, call 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss).

Please list only one family group on an application. A family group can be parents, stepparents, or adoptive parents of any age and any of their children under age 19 who are all living together. If no parents are living at home, a family group may be siblings under age 19, or children under age 19 and an adult related by blood, adoption, or marriage, or a spouse or former spouse of one of those relatives who are all living together. A family group can also be an individual or a married couple who are living together with no children under the age of 19. If more than one family group lives in your home, each family group must fill out a separate application. MassHealth will send all eligibility notices to the person who is your "head of household," and to your eligibility representative, if you have one.

Please read the attached MassHealth Member Booklet carefully before you fill out the application. Keep the booklet. It may answer questions you have later.

When you fill out the application, be sure to:

- ♦ Answer **all** questions, and fill out all sections and any supplements that apply to you and your family.
- ♦ Sign and date the application. The head of household, all applicants aged 18 or older, and all parents of any age who have children living with them must sign.
- ♦ Send proof of all income, like copies of two recent pay stubs.
- ♦ Send proof of your HIV-positive status only if you want to see if you are eligible for MassHealth because you are HIV positive.
- ♦ Send a copy of both sides of all immigration cards (or other documents that show immigration status) for every family member who is not a U.S. citizen and who is applying for MassHealth, except for MassHealth Limited, CMSP, Healthy Start, or the Uncompensated Care Pool. (See Supplement D.)

The information you give us is kept confidential, as required by state and federal laws. If you want us to share information about your MassHealth eligibility (including copies of notices we send you) with someone other than your eligibility representative, if you have one, please call MassHealth to get a MassHealth Permission to Share Information Form.

\*This information will be used to determine low-income patient status for provider payments from the Uncompensated Care Pool.

**Sign the application after you fill it out. Send the application and all other needed papers to:**

**MassHealth Enrollment Center  
Central Processing Unit  
P.O. Box 290794  
Charlestown, MA 02129-0214**

**When filling out this application, please remember the following.**

- Make sure you fill out the application correctly and completely. If we need to contact you to get more information because we do not understand what you entered on the application, it will take us longer to decide if you are eligible or not for MassHealth.
- Make sure on page 2 of the application in the Sections “Working” and “Not Working” that you answer the first question in each section correctly. Each person is **either** working **or** not working, and cannot be both.
- If you answer “yes” to the third question on page 2 of the application in the Section “Not Working” about having worked in the past 12 months, you **must** enter the amount you earned in those past 12 months.
- Make sure on page 3 of the application in the Section “Injury, Illness, or Disability” that you answer “yes” or “no” to **each of the three** questions. Do not leave any answer blank.
- If you answer “yes” to the question on page 3 of the application in the Section “Absent Parent”, then you **must** fill out Supplement C according to the instructions for Supplement C. If the other parent of the child is living in the same household as the child but does not want to apply for MassHealth, make sure to list that parent on page 1 of the application in the Section “Other Family Members.”

**If you have any questions about this application or the information you need to send, please call MassHealth at 1-888-665-9993** (TTY: 1-888-665-9997 for people with partial or total hearing loss).

When we get your filled-out, signed, and dated application, we will review it. If more information is needed, we will write or call you. **Once we get all needed information, we will make a decision about your eligibility. We will send you a written notice about this decision.**

# Medical Benefit Request

## For office use only

Screener I.D.: \_\_\_\_\_  
Date received: \_\_\_\_\_  
Interpreter code: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Entry date: \_\_\_\_\_



This is an application for **MassHealth**, the **Children's Medical Security Plan (CMSP)**, **Healthy Start**, and the **Uncompensated Care Pool**. Please answer **all** questions, and fill out all sections and any supplements that apply to you and your family. You do not have to be a U.S. citizen to get MassHealth. Please print clearly. If you need more space to finish any section on this form, please use a separate sheet of paper, and attach it to the application.

## Head of Household

HOH

1.	Last name	First name	MI	Street address		
	City	State	Zip	Mailing address (if different from street address or if living in a shelter) <input type="checkbox"/> homeless		
	Is this person applying? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , is this person a U.S. citizen? <input type="checkbox"/> yes <input type="checkbox"/> no	Social security number*		Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Spoken language choice	Written language choice	Ethnicity (optional)	Telephone numbers (List work number only if we can call you at work) Home: Work:		

## Other Family Members

➤ List all other members of your family group. *Do not repeat head of household information in this section.*  
See instruction page for description of a family group.

2.	Last name	First name	MI	Is this person applying? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , is this person a U.S. citizen? <input type="checkbox"/> yes <input type="checkbox"/> no	Social security number*	Date of birth
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race (optional)	Spoken language choice	Written language choice	Ethnicity (optional)	Relationship to head of household	
3.	Last name	First name	MI	Is this person applying? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , is this person a U.S. citizen? <input type="checkbox"/> yes <input type="checkbox"/> no	Social security number*	Date of birth
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race (optional)	Spoken language choice	Written language choice	Ethnicity (optional)	Relationship to head of household	
4.	Last name	First name	MI	Is this person applying? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , is this person a U.S. citizen? <input type="checkbox"/> yes <input type="checkbox"/> no	Social security number*	Date of birth
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race (optional)	Spoken language choice	Written language choice	Ethnicity (optional)	Relationship to head of household	
5.	Last name	First name	MI	Is this person applying? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , is this person a U.S. citizen? <input type="checkbox"/> yes <input type="checkbox"/> no	Social security number*	Date of birth
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race (optional)	Spoken language choice	Written language choice	Ethnicity (optional)	Relationship to head of household	

## Pregnancy

PRG

➤ Are you or any family member pregnant? ..... ☐ yes ☐ no

Name	Are you or this person pregnant with <input type="checkbox"/> 1 baby? <input type="checkbox"/> twins? <input type="checkbox"/> triplets? If more, how many? _____	Due date
------	--	----------

## American Indian/Alaska Native

Family members under the age of 19 who are Alaska Natives or members of a federally recognized American Indian tribe who get MassHealth Family Assistance may not have to pay any premiums for this coverage.

➤ Are you or any family member who is under the age of 19 an Alaska Native or a member of a federally recognized American Indian tribe? . . . ☐ yes ☐ no  
If **yes**, names: \_\_\_\_\_

## HIV Information (optional)

HIV

MassHealth may give benefits to people who are HIV positive who might not otherwise be eligible.

Do you or any family member who is HIV positive want to apply for these benefits? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.

- ☒ **Send proof** of income and HIV-positive status. If proof of HIV-positive status is not attached, you may get benefits for up to 60 days while we wait for proof. For more information, see the MassHealth Member Booklet.

Name(s): \_\_\_\_\_

For office use only

## General Instructions for filling out the Working section AND the Not Working section below.

- Each person is **either** working **or** not working and cannot be both.
- If you or any family member works from time to time, answer "**no**" in the **Working** section, then go to the **Not Working** section at the bottom of this page.

## Working (You must answer the first question in this section.)

EN

Are you or any family member currently working or seasonally employed? (**You must answer this question.**) . . . . . ☐ yes ☐ no

If **yes**, fill out this section.\*

If **no**, go to the next section (*Not Working*).

- ☒ **Send proof** of income, like a copy of two recent pay stubs. If self-employed, send a copy of your most recent federal tax return.

### 1. Name

A. Employer name, address, and telephone number		Type of work (Check all that apply.) <input type="checkbox"/> full-time <input type="checkbox"/> day labor <input type="checkbox"/> sheltered workshop <input type="checkbox"/> part-time <input type="checkbox"/> seasonal      yearly wage: \$ _____ <input type="checkbox"/> self-employed      yearly wage: \$ _____		For office use only (indicate weekly, biweekly, or monthly) \$ _____ \$ _____	
Is health insurance offered? ** <input type="checkbox"/> yes <input type="checkbox"/> no	Number of hours per week	Weekly pay before deductions \$ _____	Date began getting this amount of pay	HID	Hrs. _____ Hrs. _____
B. Employer name, address, and telephone number		Type of work (Check all that apply.) <input type="checkbox"/> full-time <input type="checkbox"/> day labor <input type="checkbox"/> sheltered workshop <input type="checkbox"/> part-time <input type="checkbox"/> seasonal      yearly wage: \$ _____ <input type="checkbox"/> self-employed      yearly wage: \$ _____		For office use only (indicate weekly, biweekly, or monthly) \$ _____ \$ _____	
Is health insurance offered? ** <input type="checkbox"/> yes <input type="checkbox"/> no	Number of hours per week	Weekly pay before deductions \$ _____	Date began getting this amount of pay	HID	Hrs. _____ Hrs. _____

### 2. Name

Employer name, address, and telephone number		Type of work (Check all that apply.) <input type="checkbox"/> full-time <input type="checkbox"/> day labor <input type="checkbox"/> sheltered workshop <input type="checkbox"/> part-time <input type="checkbox"/> seasonal      yearly wage: \$ _____ <input type="checkbox"/> self-employed      yearly wage: \$ _____		For office use only (indicate weekly, biweekly, or monthly) \$ _____ \$ _____	
Is health insurance offered? ** <input type="checkbox"/> yes <input type="checkbox"/> no	Number of hours per week	Weekly pay before deductions \$ _____	Date began getting this amount of pay	HID	Hrs. _____ Hrs. _____

## Not Working (You must answer the first question in this section.)

EN

Are you (or any family member who is aged 19 or older) **unemployed**, only working from time to time, or retired? . . . . . ☐ yes ☐ no

If **yes**, fill out this section and answer **ALL** questions.\*

If **no**, go to the next section (*Nonworking Income*).

Name \_\_\_\_\_

Is this person getting unemployment benefits? . . . . . ☐ yes ☐ no

Has this person worked in the past 12 months? . . . . . ☐ yes ☐ no  
(Note: If you answer "**yes**" to this question, you **MUST** enter a dollar amount on the line below.)

If **yes**, how much did this person earn in the past 12 months before taxes and deductions? \$ \_\_\_\_\_

Is this person a college student? . . . . . ☐ yes ☐ no

If **yes**, is this person eligible for health insurance from the college? . . . . . ☐ yes ☐ no

If married, is your spouse working 100 hours or more a month? . . . . . ☐ yes ☐ no

\*If you need more space, please use a separate sheet of paper, and attach it to the application.

\*\*Check yes even if you cannot get it now.

## Nonworking Income

NIN

Do you or any family member have any other income? . . . . . ☐ yes ☐ no

If **yes**, fill out this section.\*

If **no**, go to the next section (*Health Insurance*).

Please describe the source of the income (where it comes from) for each family member. If anyone has more than one source, list on separate lines.

✕ **Send proof.** Some types of other income are:

- alimony                      • dividends or interest                      • retirement                      • unemployment compensation                      • worker's compensation
- annuities                      • pensions                      • Social Security                      • veteran's benefits                      • other (please describe below)
- child support                      • rental income                      • SSI                      • trusts

Name	Type of income (all that apply from list above)	Source (where the income comes from)	Monthly amount before taxes	For office use only
			\$	
			\$	
			\$	
			\$	

## Health Insurance

Even if you or any family member have other health insurance, MassHealth may be able to help you pay your premiums.

Do you or any family member or absent parent have health insurance, or access to health insurance, including Medicare? . . . ☐ yes ☐ no

Do you or any family member or absent parent work for an employer who offers health insurance? . . . . . ☐ yes ☐ no

Did you or any family member leave a job within the last six months that offered health insurance? . . . . . ☐ yes ☐ no

If you answered **yes to any of these three questions**, you must fill out **Supplement A** (the green sheet).

## Injury, Illness, or Disability

Do you or any family member have an injury, illness, or disability that has lasted or is expected to last for at least 12 months? . . . . . ☐ yes ☐ no

Have you or any family member had an accident, illness, or injury that someone else might be responsible for? . . . . . ☐ yes ☐ no

Have you or any family member had an accident, illness, or injury that could be covered by someone else's insurance or the family member's own insurance, other than health insurance? . . . . . ☐ yes ☐ no

If you answered **yes to any of these three questions**, you must fill out **Supplement B** (the blue sheet).

## Absent Parent

Does any child in the family have a parent who does not live with you? . . . . . ☐ yes ☐ no

If **yes**, you **must** fill out **Supplement C** (the yellow sheet).

## Immigration

The citizenship status of parents does not affect the eligibility of their children.

Is every member of the family *who is applying*, including you, a U.S. citizen? . . . . . ☐ yes ☐ no

If **yes**, go to page 4. If **no**, please fill out **Supplement D** (the orange sheet). If you or any other family member applying for benefits does not fit any of the categories on Supplement D, numbered 1 through 15, you or that family member may only get one or more of the following: MassHealth Limited, Healthy Start, CMSP, or Uncompensated Care Pool.

List below the names of family members who only want to get one or more of the following: MassHealth Limited, Healthy Start, CMSP, or Uncompensated Care Pool.

Names	For office use only	Names	For office use only

\*If you need more space, please use a separate sheet of paper, and attach it to the application.

**Please read this page carefully, then sign and date the bottom of the page.**

**This is an application for MassHealth, the Children's Medical Security Plan (CMSP), Healthy Start, and the Uncompensated Care Pool.**

I give permission for my current and former employers and health insurers to release to MassHealth any and all information they have about my health-insurance coverage and health-insurance coverage for members of my family group. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to me or members of my family group.

I give permission to MassHealth to get any records or data to prove any information given on this application and any supplements to it, or other information I give to MassHealth once I am a member. If I or my family is found eligible for MassHealth, CMSP, or Healthy Start, I give permission to MassHealth to get any records about medical services provided through these programs.

I understand that if I am aged 55 or older, after I die, MassHealth may be able to get back money from my estate.

I understand that if I or any members of my family are in an accident, or are injured in some other way, and get money from a third party because of that accident or injury, we will need to use that money to repay MassHealth for certain medical services provided, as explained in the MassHealth Member Booklet. I also understand that I must tell MassHealth in writing, within 10 days, if I file any insurance claim or lawsuit because of an accident or injury to me or a family member applying for benefits.

I understand that if I or any members of my family are eligible for MassHealth, CMSP, Healthy Start, or the Uncompensated Care Pool, I must tell MassHealth of any changes in my or my family's income or employment, family size, health-insurance coverage, health-insurance premiums, and immigration status, or of changes in any other information I gave on this application and any supplements to it within 10 days of learning of the change.

I also understand that by signing below, I give permission to MassHealth to go after and collect third-party payments for medical care and medical support from the parent of any child under age 19 who is applying for benefits.

If I or any member of my family is eligible for MassHealth, CMSP, or Healthy Start, I understand that I may have to pay a premium set by MassHealth. If I am a certain American Indian or Alaska Native eligible for MassHealth Family Assistance, I may not have to pay any premiums under MassHealth Family Assistance.

I certify that I have read or had read to me the information on this application and on any supplements to it and the information in the MassHealth Member Booklet, and that I understand my rights and responsibilities. I further certify under the penalty of perjury that the information on this application and any supplements to it is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this application and any supplements to it, the enclosed MassHealth Eligibility Representative Designation Form must also be filled out and sent back with this application. Your signature on this application as an eligibility representative certifies that the information on this application and any supplements to it is correct and complete to the best of your knowledge.

If you think MassHealth's decision about whether you are eligible is wrong, you have the right to appeal or file a grievance. If you are denied benefits, you will get information about how to appeal or file a grievance.

**The head of household, all persons aged 18 or older, and all parents of any age who have children living with them who are applying for MassHealth, CMSP, Healthy Start, or the Uncompensated Care Pool, must read this page carefully, and sign and date below. If you are signing below as an eligibility representative, a filled-out MassHealth Eligibility Representative Designation Form must also be submitted.**

X

\_\_\_\_\_  
Signature of applicant or eligibility representative

\_\_\_\_\_  
Date

X

\_\_\_\_\_  
Signature of applicant or eligibility representative

\_\_\_\_\_  
Date

X

\_\_\_\_\_  
Signature of applicant or eligibility representative

\_\_\_\_\_  
Date





# Supplement A: Health-Insurance Questions

**For office use only.** Head of household name: \_\_\_\_\_ Head of household SSN: \_\_\_\_\_

**Leave this page blank if you answered NO** to all the health-insurance questions on page 3.

**Fill out this page if you answered YES** to any of the three health-insurance questions on page 3.

**You do not have to give us absent-parent information if you fill out the "Good Cause" section in Supplement C.**

## Medicare

HN

Do you or any family member who is applying get Medicare? . . . . . ☐ yes ☐ no  
If **no**, go to the next section (*Health Insurance*).  
If **yes**, fill out this section.

1.	Name	Claim number
2.	Name	Claim number

## Health Insurance

HN

If you or any family member have other health insurance, you may still be able to get MassHealth. Health insurance can be from an employer, an absent parent, a union, a school, or Medicare supplemental insurance, like Medex.

Do you or any family member or absent parent have health insurance, other than Medicare, from an employer or any other source? . . . . . ☐ yes ☐ no

If **no**, go to the next section (*Other Possible Health Insurance*).

If **yes**, fill out this section.

If you have more than one policy, or if you have other insurance like dental or vision, check here ☐, and **use the extra sections on the back of this page.**

1.	Policyholder name	Date of birth	Social security number*	Insurance company name
Names of covered family members _____ _____ _____ _____			Policy start date	Policy number
			Group number (if known)	Employer or union name
			Policy type <input type="checkbox"/> individual <input type="checkbox"/> couple (two adults) <input type="checkbox"/> dual (one adult, one child) <input type="checkbox"/> family	Policyholder contribution to premium costs \$ _____ per week    \$ _____ per quarter \$ _____ per month

## Other Possible Health Insurance

HN

We may be able to help you buy health insurance from your current or former employer. Please fill out this section if you answer **yes** to either question below, and you **do not** have health insurance.

Do you or any family member or absent parent work for an employer who offers health insurance? . . . . . ☐ yes ☐ no

Did you or any family member leave a job within the last six months that offered health insurance? . . . . . ☐ yes ☐ no

If you need more space, check here ☐, and **use the extra sections on the back of this page.**

1.	Name	Employer telephone number
Employer name		Employer address
2.	Name	Employer telephone number
Employer name		Employer address

\*Required, if obtainable and one has been issued, whether or not this person is applying.



Health Insurance (cont.)

2.

Policyholder name	Date of birth	Social security number*	Insurance company name
Names of covered family members		Policy start date	Policy number
		Group number (if known)	Employer or union name
		Policy type	Policyholder contribution to premium costs
		<input type="checkbox"/> individual	\$ _____ per week      \$ _____ per quarter
		<input type="checkbox"/> couple (two adults)	
		<input type="checkbox"/> dual (one adult, one child)	
		<input type="checkbox"/> family	\$ _____ per month

3.

Policyholder name	Date of birth	Social security number*	Insurance company name
Names of covered family members		Policy start date	Policy number
		Group number (if known)	Employer or union name
		Policy type	Policyholder contribution to premium costs
		<input type="checkbox"/> individual	\$ _____ per week      \$ _____ per quarter
		<input type="checkbox"/> couple (two adults)	
		<input type="checkbox"/> dual (one adult, one child)	
		<input type="checkbox"/> family	\$ _____ per month

Other Possible Health Insurance (cont.)

3.

Name	Employer telephone number
Employer name	Employer address

4.

Name	Employer telephone number
Employer name	Employer address

\*Required, if obtainable and one has been issued, whether or not this person is applying.



# Supplement B: Injury, Illness, or Disability Questions

**For office use only.** Head of household name: \_\_\_\_\_ Head of household SSN: \_\_\_\_\_

**Leave this page blank if you answered NO** to all the injury, illness, and disability questions on page 3.

**Fill out this page if you answered YES** to any of the three injury, illness, and disability questions on page 3.

## Injury, Illness, or Disability

PDJ/  
DDJ

Fill out this section for you or any family member who has an injury, illness, or disability.

1.	Name	For office use only		
		Supp to DES	Dis type	
▶	Does this person have an injury, illness, or disability that has lasted or is expected to last for at least 12 months? . . . . .	<input type="checkbox"/> yes	<input type="checkbox"/> no	
	Does this person get money from Social Security for a disability? . . . . .	<input type="checkbox"/> yes	<input type="checkbox"/> no	
	Has this person ever gotten Supplemental Security Income (SSI)? . . . . .	<input type="checkbox"/> yes	<input type="checkbox"/> no	
	Is this person legally blind? . . . . .	<input type="checkbox"/> yes	<input type="checkbox"/> no	
	<input checked="" type="checkbox"/> If <b>yes</b> , send a copy of the Certificate of Blindness.			
2.	Name	For office use only		
		Supp to DES	Dis type	
		Does this person have an injury, illness, or disability that has lasted or is expected to last for at least 12 months? . . . . .	<input type="checkbox"/> yes	<input type="checkbox"/> no
		Does this person get money from Social Security for a disability? . . . . .	<input type="checkbox"/> yes	<input type="checkbox"/> no
		Has this person ever gotten Supplemental Security Income (SSI)? . . . . .	<input type="checkbox"/> yes	<input type="checkbox"/> no
▶	Is this person legally blind? . . . . .	<input type="checkbox"/> yes	<input type="checkbox"/> no	
<input checked="" type="checkbox"/> If <b>yes</b> , send a copy of the Certificate of Blindness.				

## Accident or Injury

TPR

You must answer the following three questions about you or any family member who needs health care because of an accident or injury.

		For office use only	
▶	Are you or any family member applying because of an accident or injury that someone else might be responsible for? . . . . .	<input type="checkbox"/> yes <input type="checkbox"/> no	
If <b>yes</b> , names: _____			
▶	Do you or any family member have an injury, illness, or disability that was caused by someone else, or that could be covered by someone else's insurance or the family member's own insurance, other than health insurance (like homeowner's or auto insurance)? . . . . .		<input type="checkbox"/> yes <input type="checkbox"/> no
If <b>yes</b> , names: _____			
▶	Has a lawsuit, a worker's compensation claim, or an insurance claim for an accident or injury been filed for you or any family member who is applying? . . . . .	<input type="checkbox"/> yes <input type="checkbox"/> no	
If <b>yes</b> , names: _____			

If you need more space, please use the back of this page.





# Supplement C: Absent-Parent Questions and Assignment of Rights

**Do not fill out this supplement if you answered NO** to the absent-parent question on page 3.

**Fill out this supplement only if you answered YES** to the absent-parent question on page 3.

## Absent Parent

### PART A—Cooperation

To get MassHealth for you and a child who is living with you, you must cooperate with the Child Support Enforcement Division of the Massachusetts Department of Revenue (DOR) to establish paternity and enforce a medical-support order, unless you have Good Cause not to cooperate. You must also assign your rights for medical support to MassHealth. Cooperation means that you may have to give information about the identity, location, and employment of the absent parent, appear for appointments with DOR staff and the Court, submit to paternity testing, give information, and take any other action necessary to help DOR in establishing paternity, and establishing, changing, or enforcing a child medical-support order. “Good Cause” is a legal term that means if you cooperated by giving us information about the absent parent, it would not be in the best interests of the child for any of the reasons listed in Part B—Good Cause—on the next page. If you think that you have Good Cause for not cooperating, fill out Part B—Good Cause—on the next page, and do not fill out Part C—Absent-Parent Information—on the next page.

If you do not want to make a Good Cause claim, and you do not cooperate by filling out Part C—Absent-Parent Information—on the next page, your MassHealth eligibility could be affected.

To get MassHealth only for the child who is living with you and not for yourself, you do not have to cooperate with DOR, assign your rights for medical support to MassHealth, or give information about the absent parent. Also, if a pregnant family member is applying for benefits for an unborn child, you do not need to give us information about the absent parent of the unborn child at this time. This means that you do not have to fill out Part B, C, or D of this supplement for that unborn child. Please read the next paragraph about child-support-enforcement services.

Even if you are applying for MassHealth only for the child who is living with you, you can ask for child-support-enforcement services if you want help getting the absent parent to pay for health insurance or child support for the child. To do this, you can call DOR at 1-800-332-2733, or go to [www.mass.gov/dor](http://www.mass.gov/dor) and click on “Child Support.” The child’s MassHealth coverage will not be affected if you choose to ask for these services or not. If you ask for these services, you will have to cooperate with DOR.

**Please go to page 10.**



# Supplement C: Absent-Parent Questions and Assignment of Rights

**For office use only.** Head of household name: \_\_\_\_\_ Head of household SSN: \_\_\_\_\_

**Please read Part A of Supplement C (page 9) before you fill out Parts B, C, and D of Supplement C (below).**

## Absent Parent (cont.)

ABS

### PART B—Good Cause

Is there any reason (Good Cause) not to help us get medical support from an absent parent? . . . . . ☐ yes ☐ no

If **no**, fill out Part C—Absent-Parent Information—below.

If **yes**, list the name(s) of the child or children whose absent parent(s) you do not want to give us information about, and check one of the boxes below for the reason that applies to the child or children.

Name(s): \_\_\_\_\_ Name(s): \_\_\_\_\_

☐ Cooperation could result in serious physical or emotional harm to a family member or his or her child, or the applicant or member.

☐ Adoption of the child is in process.

☐ The child was a result of sexual abuse or assault.

☐ Cooperation could result in serious physical or emotional harm to a family member or his or her child, or the applicant or member.

☐ Adoption of the child is in process.

☐ The child was a result of sexual abuse or assault.

### PART C—Absent-Parent Information (if known)

1. Name	Social security number*	Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address		Telephone number	

Is there a medical-support order? . . . . . ☐ yes ☐ no

Relationship to child: ☐ Mother ☐ Father ☐ Other: \_\_\_\_\_ Driver's license number:\* \_\_\_\_\_

Names of children of this absent parent: \_\_\_\_\_

Name and address of absent-parent's employer: \_\_\_\_\_

*\*Required, if obtainable and one has been issued.*

2. Name	Social security number*	Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address		Telephone number	

Is there a medical-support order? . . . . . ☐ yes ☐ no

Relationship to child: ☐ Mother ☐ Father ☐ Other: \_\_\_\_\_ Driver's license number:\* \_\_\_\_\_

Names of children of this absent parent: \_\_\_\_\_

Name and address of absent-parent's employer: \_\_\_\_\_

*\*Required, if obtainable and one has been issued.*

### PART D—Signature

I am the parent whom the child lives with (custodial parent) or legal guardian, and I understand that by signing below I assign my rights and give permission to MassHealth and DOR to go after medical support from the absent parent of any child under age 19 who is living with me and applying for MassHealth. I also agree to cooperate with MassHealth and DOR in this process, as explained in Part A—Cooperation—of this supplement.

\*\*Signature of custodial parent or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

*\*\*Required, only if you are applying for yourself and the child who is living with you.*

If you need more space, please use a separate sheet of paper, and attach it to this supplement.



# Supplement D: Questions for Immigrants

**For office use only.** Head of household name: \_\_\_\_\_ Head of household SSN: \_\_\_\_\_

**Leave this page blank if you answered YES** to the immigration question on page 3.

**Fill out this page if you answered NO** to the immigration question on page 3.

➤ 1. Are you or any family member on active duty, or a veteran of the United States Armed Forces with an honorable discharge, or did you or any family member serve under U.S. command during World War II or in Vietnam? . . . . . ☐ yes ☐ no  
If **yes**, you may stop here.  
If **no**, go to the next question.

➤ 2. Are you or any family member the spouse, widow or widower, or dependent of a person on active duty or a veteran described above? . . . . . ☐ yes ☐ no  
If **yes**, you may stop here.  
If **no**, go to the next question.

➤ 3. Are you or any family member a victim of domestic abuse and **no longer living with the abuser**? . . . . . ☐ yes ☐ no  
If **yes**, you may stop here.  
If **no**, you must fill out the rest of this page (*Immigration Status*).

## Immigration Status

OAC

➤ Fill out the chart below for each member of the family who is **not** a U.S. citizen and who is applying for MassHealth. List *all* statuses that have applied to each person since that person entered the U.S.

✉ **Send copies** of both sides of all immigration cards (or other documents that show immigration status).  
See the *MassHealth Member Booklet* for a more complete description of immigration statuses.

**Note:** Family members who only want to get one or more of the following: MassHealth Limited, CMSP, Healthy Start, or Uncompensated Care Pool, do not have to give us a social security number. We will not match their names with any other agency including the Department of Homeland Security (DHS). You do not need to list their names on this page or send proof of their immigration status. But you must list their names in the orange block on page 3. MassHealth Limited pays for emergency services only. See the *MassHealth Member Booklet* for more information.

➤ Use these codes to describe your status in the chart below:

4. Amerasian admitted pursuant to Section 584 of Public Law 100-202	6. Conditional entrant	10. Native American with at least 50% American Indian blood born in Canada	13. Person with a temporary visa/other
5. Granted asylum	7. Cuban/Haitian entrant	11. Granted parole	14. Person residing under color of law (PRUCOL) (See the <i>MassHealth Member Booklet</i> for more information.)
	8. Deportation withheld	12. Refugee	15. Victim of severe forms of trafficking
	9. Legal permanent resident		

Name	Status codes (List all that apply.)				Date status awarded				U.S. entry date	For office use only
	a	b	c	d	a	b	c	d		

If you need more space, please use a separate sheet of paper, and attach it to the application.



## Did you remember to:

- ♦ Read the instructions on the instruction page?
- ♦ Fill out a separate application for each family group?
- ♦ **Answer all questions, and fill out all sections and any supplements that apply to you and your family?** You do not have to send back any supplements that do not apply.
- ♦ Sign and date the application on page 4? Remember, the head of household, all applicants aged 18 or older, and all parents of any age who have children living with them must sign.
- ♦ Submit a filled-out MassHealth Eligibility Representative Designation Form, if you are filling out this application as an eligibility representative or if you want someone to act on your behalf?
- ♦ Send proof of all income, like copies of two recent pay stubs, copies of any benefit checks or award letters, or copies of your most recent federal tax return with schedules?
- ♦ Send proof of your HIV-positive status only if you want to see if you are eligible for MassHealth because you are HIV positive? MassHealth may give benefits to people who are HIV positive who might not otherwise be eligible. If you apply because you are HIV positive, and do not give us proof of your HIV-positive status now, we will need to send you a letter asking for this proof. The letter will be sent to the address you gave us on this application. Proof can be a letter from your doctor, clinic, lab, or AIDS service provider or organization that shows the name of the person who is HIV positive and his or her positive test result.
- ♦ Send a copy of both sides of all immigration cards (or other documents that show immigration status) for every family member who is **not** a U.S. citizen and who is applying? (See Supplement D.)

Please staple, clip, or attach all needed papers to your application.

**When you have filled out and signed this application,  
send it with all other needed papers to:**

MassHealth Enrollment Center  
Central Processing Unit  
P.O. Box 290794  
Charlestown, MA 02129-0214